Department of HUMAN SERVICES

Health Home Learning Collaborative

Transitional Care

February 2022

This Training is a Collaborative Effort Between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Introductions
2. Transitional Care……..…….Martha Boese AGP
3. Health Home Case Study/Health Home Spotlight…….Sue Brooks/Four Oaks
4. Questions/Open Discussion……..…All

Coming up (Subject to change):

- *March 21, 2022: Care Coordination: Understanding Long-term Care Services, Medicaid Programs, Mental Health & Disability Service Regions, & Court-ordered Services*

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

Learning Objectives

- Transitions Types
  - Hospital Admissions
  - Home vs. other settings
  - Reasons for transitions/HH responses
    - Member needs
    - Member supports
    - Member follow – up
- Discharge Planning
- Susan Brooks, Director
  - Four Oakes Integrated Health Home
    - PMIC Program: Expect success
    - Family involvement
    - Discharge planning

TYPES OF TRANSITIONS

Hospital Admission

- If Member was in Community:
  - Inform Providers
  - Complete CIR
  - Discuss discharge plan

- If Member was in a Nursing Facility:
  - Contact MCO CBCM
  - Determine the bed level

Transitioning & the Health Plan

Returning Home vs. Transitioning into Facility Living

Home to:
- Hospital
- HCBS Setting
- Facility (NF, SNF, RCF, LTC, etc.

Hospital to:
- Home
- Facility

Nursing Facility to:
- Home

HCBS setting to :
- Home
- HCBS site

Facility to:
- Facility
- Home

Other reasons for transitions & health home responses

WHY TRANSITION?

- Facility ≠ Member needs
- Member ≠ care for self ≠ inadequate support in home
- Member individual desires aspirations for independence

HEALTH HOME RESPONSIBILITY

- Support Member during transition
- Work with Member and support system

GOALS OF TRANSITION

Help member obtain living environment that is the:

- Most integrated
- Least restrictive
- Safest

Help Member:

- Work directly with Member
- Instill confidence in Member
- Support Member

DISCHARGE PLANNING

Hospital Discharge Planning

- Review member needs
- Where is member going?
- What support or resources are needed?

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- Work with member's support
- Coordinate and establish new services
- Contact providers to initiate services

Hospital Discharge Planning

- Review member needs
- Where is member going?
- What support or resources are needed?

- Work with member's support
- Coordinate and establish new services
- Contact providers to initiate services

- Member is discharged
- Follow-up with member

Department of HUMAN SERVICES

Susan Brooks, Director, Integrated Health

FOUR OAKS
expect success

WHY did Four Oaks start PMIC program?

2019: Enrollments were falling through the cracks

Four Oaks Philosophy: IHH provides community based case management/Care coordination *begins* at admission:

- Capturing enrollment early = better work flow

How did Four Oaks get organizational "buy – in?"

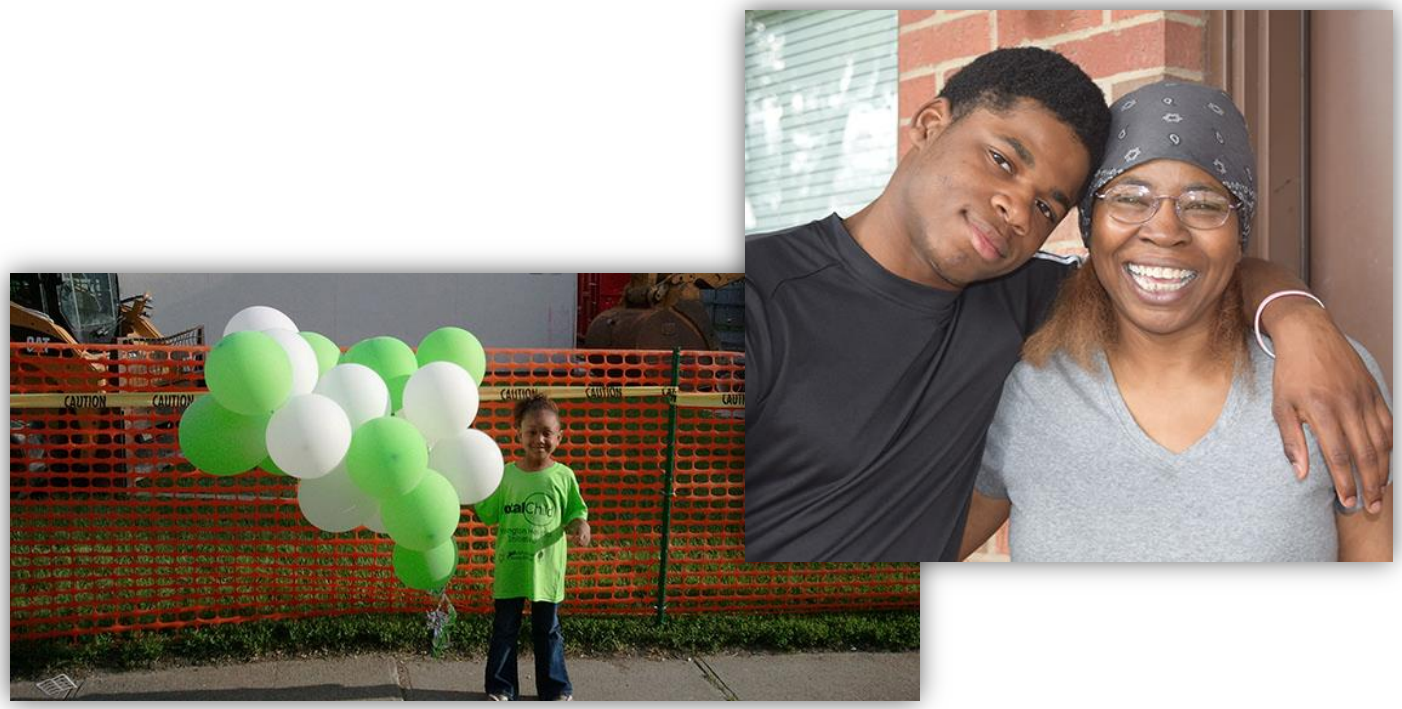
- Agency commitment to collaboration
- Cohesiveness
- Team integration

EXPECT SUCCESS

- 95% PMIC kids attached to IHH; starts with buy in with agency
  - Values collaboration of services for continuity of care
  - Knowing we can't all do it on our own
    - we each have different expertise
- "Silo-ing" doesn't help families:
  - Introduces treatment team in PMIC
  - Families continue as part of your team when you d/c from PMIC
- IHH becomes part of the PMIC treatment plan and is
  - Part of family intake packet
  - If member is already part of an IHH they connect with them immediately and IHH becomes part of treatment team and discharge planning

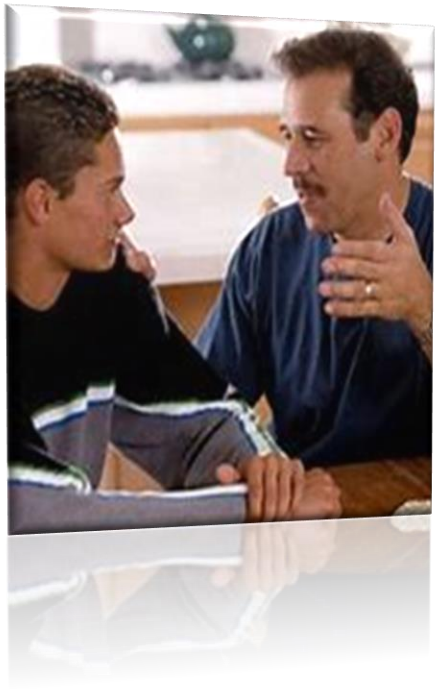
- Dedicated staff member (Terry, IHH Care Coordinator) that only does PMIC admissions:
    - Families need choice of IHHs: learn/relearn value of IHH
    - Terry enrolls them in Four Oaks IHH
    - Gets local IHH connection to PMIC team, or reach out to d/c from other IHH the family may be involved with so they can become involved with Four Oaks IHH
    - Always visits with family prior to treatment plan
        - "Uplifts" family to case manager
    - Works closely with case managers
    - Prioritizes discharge staffing
    - Attends every staffing for PMIC (if conflict will have other staff member stand in at meeting in his absence)

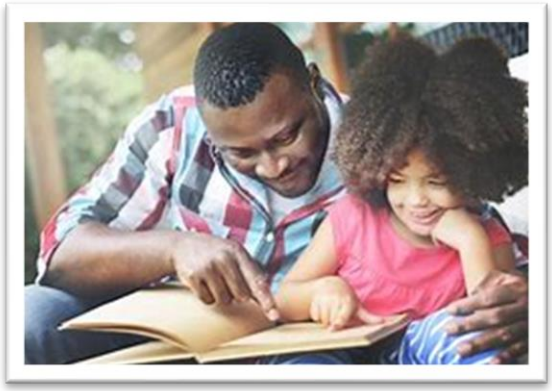
- Mason City PMIC (smaller)
    - One staff member is responsible for a dormitory
    - IHH will follow child back into the community



Getting Families Involved

- ✓ Discussion/Engagement with family
  - ➢ Put family at ease: What is “treatment?”
- ✓ Conversation with parents
  - ➢ Address help child is/will be receiving
  - ➢ Address help available to parents





Discharge planning begins at **admission**!

- ✓ Get Behavioral Health Intervention Services (BHIS) in child's home
- ✓ Identify other children in home that qualify for therapy and/or BHIS
- ✓ Acquire insurance information/support for the family
- ✓ Ensure a safety plan is in place
- ✓ Case management is involved with this process
  - Terry has developed care plan **prior** to discharge
  - Terry is available to family in **collaboration** with community based case manager
  - Nurse and Family/Peer Support Specialists available to family

Handoff is a WARM handoff!

PEER TO PEER SHARING

What transitions activities does your organization use that work well?

What are your biggest challenges?

How do others deal with these challenges and/or have successfully overcome these barriers?

Questions?

Thank you!